Fact Sheet

Health Disparities Amoung Youth and Young Adults

According to the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, "socioeconomic, racial, and ethnic disparities in health status are *large, persistent*, and *ever increasing* in the United States." When elements of racism, poverty, and community environment converge, greater overall threats to health develop. Most communities and ethnic groups that experience disparate health status have worse outcomes than whites across a broad spectrum of illnesses, injuries and treatment outcomes.

There are many factors that contribute to disparities in health. Some factors include: poverty, racial segregation, lower educational attainment, high unemployment, single parent households, limited access to care, lower quality housing, poorer environmental conditions, limited social opportunities, cultural differences, beliefs and norms, lack of language translation services, acculturation – seeking care and citizenship, lack of culturally diverse workforce, unfamiliarity with biomedicine, culturally insensitive providers, limited policies to address disparities, neighborhood context, nutritional differences, stress from discrimination, lack of hope, social support networks, mistrust, confidentiality, concentrated poverty, fragmentation of services, lower cost, lower quality medical care, provider bias/stereotyping, long waits and lack of transportation.

Tennessee Data

- The death rate for African American youth ages 10 to 14 for 2001 was 26.1 per 100,000 compared to white youth at 22 per 100,000 and 6.8 per 100,000 for all other races.
- African American males ages 10-24 are 15 times more likely to die from homicide than white males.
- 60% of young people ages 10-24 who died from motor vehicle crashes were white males, followed by 26% white females, 9% African American males, and 4% African American females.
- Victimization of partner violence among high school teens is higher in African American teens (13.5%) than in white teens (8.8%).
- More white high school students (29%) report binge drinking compared to African American students (12.5%).
- African American high school males (52.6%) report more frequent marijuana use than white males (43.4%), African American females (39.5%) and white females (38.9%).
- The suicide rate is highest among young adults ages 20-24 (13.6 per 100,000) compared to youth ages 15-19 (6.4 per 100,000) and 10-14 (1.5 per 100,000).
- Males ages 10-24 complete suicide at rates approximately four times higher than females.
- White males ages 10-24 (13.1 per 100,000) were almost 2 times more likely to die from suicide than African American males (7.9 per 100,000).
- More female high school students (17.8%) had made a suicide plan than males (10.3 %).
- The birth rate for African American females (20.2 per 100,000) ages 10-17 is twice the rate of white teens (9.7 per 100,000).
- Pregnancy rates for Tennessee's African American females ages 10-17 are two and one/half times higher than their white counter parts.
- Teen pregnancies among Hispanic youth are increasing whereas rates are decreasing for all other races.

- In 2003 there were more than twice as many infant deaths to young African American mothers ages 10-17 (291 infant deaths or 18 per 1,000) compared to young white mothers (424 infant deaths or 7 per 1,000).
- As of June 2003 there were 472 Tennessee youth, ages 10 to 24 who were living with HIV/AIDS. An overwhelming 76.9% of all youth infected are African American.
- There are many more overweight high school males (17%) than females (12%) in Tennessee.
- African American high school females (22%) are more than twice as likely to be overweight than their white female counterparts (8.8%).

Best Practices

Cultural and linguistic competency

States can develop standards tailored to community needs, collect data to identify service needs, finance interpreter services, and increase the supply of minority health providers.

Data

States have a critical role in fostering collection, analysis, and use of minority health data for the identification and amelioration of disparities.

Insurance coverage

More than half of the uninsured youth in the United States belong to racial and ethnic minorities.. States should expand eligibility, encourage enrollment, and eliminate administrative obstacles to promote wider coverage.

Primary care

States can expand the number and capacity of community health centers, reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations.

Purchasing

States can use their extensive purchasing power to require data collection and reporting, mandate consumer satisfaction surveys, and require specific health interventions.

Regulatory approaches

States can influence professionals, institutions, and health plans by using licensure and other regulatory requirements to address provider and facility shortages in minority communities.

State infrastructure

States can help minority health offices reduce disparities by ensuring that these offices have adequate financial resources (many are channeling revenue from the Tobacco Settlement), limit staff turnover, foster good relations with other state agencies, legislative and/or regulatory grounding, access to data, and clear performance measures.

Workforce development

States can foster a more diverse health workforce by diversifying applicant pools, developing incentive programs, ensuring adequate data collection, and using Graduate Medical Education funds more creatively.

Involve all health system stakeholders

Issues related to minority health and health disparities can be easily pigeon-holed so that policymakers have only limited exposure to them. Yet any effective strategy requires the full engagement of state governments — including executive and legislative branch leaders — and the broader health sector — including hospitals, physicians, community health centers, nurses, home health providers, the public health community, community-based organizations, and more. An effective strategy must also engage the broader public through community-based public education activities and programs.

Websites

Center for Linguistic and Cultural Competence in Health Care, Office of Minority Health
http://www.omhrc.gov/cultural/index.htm

National Alliance for Hispanic Health
http://www.hispanichealth.org/

National Center for Cultural Competency
http://gucchd.georgetown.edu/nccc/index.html

National Center on Minority Health and Health Disparities
http://www.nih.gov/about/almanac/organization/NCMHD.htm

Tennessee Office of Minority Health
http://www2.state.tn.us/health/minorityhealth/index.html